SCHEDULE OF BENEFITS – (PLAN TROOPERS – HDHP TARGET PLAN 2)

In-Network benefits are based on the Preferred Provider Organization's approved amount. Out-of-Network benefits are based on the Reasonable and Customary amount. Benefits are determined after any applicable Deductible and Coinsurance, and are subject to Annual, Lifetime and Other Maximums, General Exclusions and other applicable limitations.		
Deductible	**In-Network**	**Out-of-Network**
- Individual	$1,500	
- Family, aggregate	$3,000	
Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.		
"Aggregate" = If the certificate is covering a family, no benefits are payable for any individual within a family until the entire Family Deductible is satisfied. Claims paid after the Family Deductible is satisfied will have no additional Deductible taken for the entire family.	In-Network and Out-of-Network Deductibles accumulate together.	
Coinsurance Maximum	**In-Network**	**Out-of-Network**
- Individual	$1,000	
- Family, aggregate	$2,000	
Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.		
"Aggregate" = If the certificate is covering a family, the entire Family Coinsurance Maximum must be satisfied. Claims paid after the Family Coinsurance Maximum is satisfied will have no additional Coinsurance taken for the entire family.	In-Network and Out-of-Network Coinsurance Maximums accumulate together.	
Cost Sharing Maximum	**In-Network**	**Out-of-Network**
- Individual	$6,350	
- Family, aggregate	$12,700	
Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.		
"Aggregate" = If the certificate is covering a family, the entire Family Cost Sharing Maximum must be satisfied. Claims paid after the Family Cost Sharing Maximum is satisfied will have no additional Cost Sharing (Deductible, Coinsurance, and Copays) taken for the entire family.	In-Network and Out-of-Network Cost Sharing Maximums accumulate together.	

SCHEDULE OF BENEFITS – (PLAN TROOPERS – HDHP TARGET PLAN 2)

You pay after the Copay and/or Deductible as stated.
"No Charge" = No Copay, No Deductible, and No Coinsurance.

	We Pay In-Network	We Pay Out-of-Network
CHARGES FOR PREVENTIVE CARE SERVICES		
The following Preventive Care and Screening Services: • Annual Adult Preventive Exam • Annual Gynecological Exam • Fecal Occult Blood Screening • Prostate Specific Antigen (PSA) Screening	100%	Not Covered
All Other Preventive Care and Screening Services and Immunizations for children, adolescents and adults that: -- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or -- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or -- are provided for in comprehensive guidelines supported by the Health Resources and Services Administration, with respect to the individual involved. -- Includes annual routine vision exam as part of a physical to determine vision loss. ********** Please consult the recommendations and guidelines for age, frequency and other guidelines. Some examples of screening include high blood pressure, breast cancer (mammograms), cervical cancer (PAP), cholesterol, depression, diabetes, colorectal cancer (colonoscopies), and prostate cancer (PSA). Examples of immunizations include HIV, DTP, Hepatitis A, Hepatitis B, HIB, HPV, MMR, and Flu Shots. Copies of the recommendations and guidelines may be obtained from the following web sites. You may also call 800-211-1534 to obtain a no-cost paper copy from US Health and Life Insurance Company. https://www.healthcare.gov/what-are-my-preventive-care-benefits/ http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html www.hrsa.gov	100%	Not Covered
CHARGES FOR PHYSICIAN AND FACILITY SERVICES - URGENT CARE AND EMERGENCY		
Urgent Care Facility	80% after $10 copay and Deductible	60% after Deductible
Urgent Care Physician	80% after Deductible	60% after Deductible
Emergency Room Facility	80% after $100 copay and Deductible	
Emergency Room Physician	80% after In-Network Deductible	
Ambulance	80% after In-Network Deductible	

No copayment, deductible, or coinsurance applies to Out-of-Network emergency services if the In-Network Cost Sharing Maximum has been reached. Out-of-Network providers will be reimbursed at the same level of benefits as In-Network providers, and they may bill you for the balance.

SCHEDULE OF BENEFITS – (PLAN TROOPERS – HDHP TARGET PLAN 2)

	We Pay In-Network	We Pay Out-of-Network
CHARGES FOR PHYSICIAN AND FACILITY SERVICES - OTHER THAN URGENT CARE AND EMERGENCY (INCLUDES MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)		
Office Visit	80% after $10 copay and Deductible	60% after Deductible
Inpatient Facility	80% after Deductible	60% after Deductible
Inpatient Physician	80% after Deductible	60% after Deductible
Outpatient Facility	80% after Deductible	60% after Deductible
Outpatient Physician	80% after Deductible	60% after Deductible
Surgical Care Facility	80% after Deductible	60% after Deductible
Surgical Care Physician (Surgeon) – Inpatient (including maternity)	80% after $10 copay and Deductible	60% after Deductible
Surgical Care Physician (Surgeon) - Outpatient	80% after $10 copay and Deductible	60% after Deductible
Diagnostic X-Ray, Laboratory and Advanced Imaging	80% after $10 copay and Deductible	60% after Deductible
Independent Laboratory Services Ordered by a Non-Network Physician	80% after $10 copay and Deductible	60% after Deductible
Independent Laboratory Services Ordered by a Network Physician	80% after $5 copay and Deductible	
Allergy Testing and Injections	80% after Deductible	60% after Deductible
CHARGES FOR OTHER SERVICES		
Durable Medical Equipment	80% after In-Network Deductible	
Human Organ Transplant	80% after Deductible	60% after Deductible
Hospice	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Skilled Nursing Care – Nursing Home (Maximum 45 days per Calendar Year)	80% after Deductible	60% after Deductible
Skilled Nursing Care – Residential Home	Not Covered	Not Covered
Infertility Counseling and Treatment (Limited Benefits)	80% after Deductible	Not Covered
Inpatient Rehabilitation Facility	80% after Deductible	60% after Deductible
Psychiatric Facility Inpatient / Outpatient	80% after Deductible	60% after Deductible
Substance Abuse Facility Inpatient / Outpatient	80% after Deductible	60% after Deductible
Partial Hospital Program for Mental Health	80% after Deductible	60% after Deductible
Dietician Services (Maximum 6 visits per Calendar Year)	80% after $10 copay and Deductible	60% after Deductible
LASIK Surgery Inpatient / Outpatient	80% after Deductible	Not Covered

	We Pay In-Network	We Pay Out-of-Network
Hearing Examination Audiology test covered with medical diagnosis	80% after Deductible	Not Covered
Hearing Aids	80% after Deductible	Not Covered
Male Sterilization Inpatient Outpatient	80% after Deductible	Not Covered
Prosthetics	80% after Deductible	60% after Deductible
CHARGES FOR THERAPY SERVICES		
Rehabilitative Services Outpatient Speech Therapy Outpatient Physical Therapy Outpatient Occupational Therapy	In Physician's Office: 80% after $10 copay and Deductible Other Location: 80% after Deductible	60% after Deductible
Habilitative Services Outpatient Speech Therapy Outpatient Physical Therapy Outpatient Occupational Therapy	In Physician's Office: 80% after $10 copay and Deductible Other Location: 80% after Deductible	60% after Deductible
Spinal Manipulation Maximum 30 visits per Calendar Year	80% after Deductible	60% after Deductible
CHARGES FOR PEDIATRIC VISION SERVICES		
Pediatric Vision Benefits for Children under Age 19 Calendar Year Maximums: • 1 routine exam • 1 pair eyeglass lenses or contact lenses • 1 frame	100% after Deductible	60% after Deductible
PRESCRIPTION DRUG CARD CHARGES		
Before Deductible is Satisfied	Subject to Deductible	
After Deductible is Satisfied	See Prescription Drug Schedule for applicable Prescription Drug Copay, Deductible, and Coinsurance	